

Paving the Way to Simpler: Experience from Maximizing Enrollment States in Streamlining Eligibility and Enrollment

A Maximizing Enrollment Report

By

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Maximizing Enrollment Program*

Maximizing Enrollment is a national program of the Robert Wood Johnson Foundation with technical assistance and direction provided by the National Academy for State Health Policy.

About Maximizing Enrollment

Maximizing Enrollment has worked intensively with eight states to improve eligibility and enrollment systems, policies, and procedures. This report examines steps states took to reduce burden on eligibility staff and improve customer experiences by simplifying and streamlining each step of the enrollment and retention process for Medicaid and CHIP programs.

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Dear Reader,

In 2009, eight states—Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin—received million-dollar grants from the Robert Wood Johnson Foundation's Maximizing Enrollment program to improve enrollment and retention of children in Medicaid and the Children's Health Insurance Program (CHIP), and to promote best practices in enrollment simplification that could offer new models for the nation. With the enactment of the Affordable Care Act (ACA) in 2010, the Foundation expanded the goal of the program to encompass state eligibility and enrollment strategies to prepare for newly eligible individuals in 2014.

The grantee states participated in a diagnostic assessment to identify areas of strength, challenges and opportunities; created improvement plans; received technical assistance; and participated in a peer-learning network. Four years later, Maximizing Enrollment grantee states have implemented new strategies and pioneered innovations to streamline and simplify eligibility, enrollment and retention. They used grant funds to revamp cumbersome, paper-driven enrollment processes, modernize systems, change business processes, and procure new tools.

In this series of final reports, the National Academy for State Health Policy (NASHP)—the national program office for Maximizing Enrollment—will explore the results of states' efforts to:

- Harness technology to make enrollment more simple, efficient, and accessible;
- Simplify and streamline processes to reduce unnecessary paperwork and relieve burden on both applicants and eligibility workers; and
- Manage programmatic change by setting a consistent, data-driven vision for coverage among the state agencies and local entities that share responsibility for health and human services programs.

Please visit www.maxenroll.org to download the reports in this series and to access archived webcasts to help states and policymakers learn more about our states' work to transform their enrollment systems and policies.

Sincerely,



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Our sincere thanks to the Robert Wood Johnson Foundation for its support, to our partners and technical assistance faculty, and especially to the state teams who participated in the Maximizing Enrollment program.

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Executive Summary

Since 2009, the eight states (Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin) participating in the Robert Wood Johnson Foundation's Maximizing Enrollment program have worked to streamline and simplify enrollment systems, policies, and processes for children and those eligible for coverage in 2014. The participating states aimed to reduce enrollment barriers for consumers and administrative burdens in processing applications and renewals for staff by making improvements and simplifications at every step of the enrollment process. Although the states began their work before the enactment of the Affordable Care Act (ACA), their efforts positioned them well for implementation in 2014, and offer experiences and lessons that other states may find useful in their efforts to improve efficiency, lower costs, and promote responsible stewardship of limited public resources.

States worked to simplify and streamline enrollment and retention systems by focusing on five key areas: 1) applications, 2) eligibility determinations, 3) renewals and transfers, 4) notices, and 5) business processes. In each of these areas, states sought to utilize new technologies, improve workflow management and streamline program tasks within and across agencies in order to increase enrollment for those eligible in public health coverage, while reducing administrative burden on staff.

Maximizing Enrollment states worked to improve their application forms while complying with new ACA requirements. Requirements include the use of a single streamlined application for all insurance affordability programs (IAPs) and providing a “no wrong door” approach to enrollment. A few Maximizing Enrollment states pilot tested other ACA-required simplifications or took additional steps that other states may want to consider for post-ACA simplifications. Strategies used by Maximizing Enrollment states to simplify application and renewal forms and procedures include:

- *Combining Medicaid and CHIP Application and Renewal Forms to create a single form to be used for both initial enrollment and renewals that streamlines collection and review of data.*
- *Scanning/Uploading Verifications Electronically to allow consumers to submit all application information online, reducing paper documentation.*
- *System Interfaces that Reduces Processing Burdens, minimizing the need for staff to re-key data from one system to another.*
- *Seeking User Inputs to Streamline Applications to identify barriers, such as unclear questions, and ensure language is simple, clear and understandable.*
- *Eliminating In-Person Interview Requirement, allowing consumers to apply for coverage where and when it is convenient for them*

States improved eligibility determination processes with an aim to increase staff efficiency and accuracy while improving the customer experience. While states considered and implemented smaller procedural changes, two simplification strategies had a significant impact on state eligibility processes:

- *Express Lane Eligibility (ELE) allows states to identify eligible, but unenrolled individuals; simplify eligibility procedures; and automate enrollment and renewal by using eligibility data from other human service programs.*
- *Automated Newborn Enrollment allows babies born to mothers enrolled in Medicaid or CHIP to be enrolled in coverage through an automated process between the hospital and the state, resulting in a medical ID number within 72 hours, ensuring access to immediate follow-up care.*

Maximizing Enrollment states made strides to simplify their renewal processes to increase retention and smooth case transfers between agencies. States made efforts to reduce the burden of renewals on both families and staff and to eliminate gaps in coverage for eligible individuals. Influential changes to renewal procedures included:

- *Minimizing Enrollee Submissions* of information to complete renewals and instead leveraging information the state already has through institutionalizing ex parte, administrative, and administrative renewals, as well as using Express Lane Eligibility policies and procedures.
- *Lengthening Renewal Periods* by requiring recertification every 12 months, which is now required under the ACA. States may also choose to move to a standard annual renewal that aligns Medicaid, CHIP and Exchange. One state piloted off-cycle renewals that allow consumers to renew their health coverage during an interaction with another state office before the scheduled renewal date.
- *Modifying Premium Payment Methods* to include grace periods for nonpayment of premiums, the elimination or reduction of coverage lock-out periods for nonpayment, and multiple methods for premium payment, such as via credit cards.

Maximizing Enrollment states focused on improving their communication with individuals by updating their notices. Notices are written communications from the state to the applicants that share information regarding the applicants' eligibility, from requests for more information to coverage determinations. It is important that notices provide clear, usable information to applicants and enrollees. Massachusetts is an example of a state that worked to redesign its notices by focusing on:

- *Using plain language and formatting* to make notices more understandable, accessible and easier to navigate for consumers.
- *Field testing notices* to ensure the target audience understands them.

Maximizing Enrollment states made efforts to streamline their business processes—making them simpler, more rational and consistent with new technological updates. The states analyzed their processes by mapping each step in making an eligibility or renewal determination. Streamlining efforts involved the elimination, improvement, or automation of unnecessary or inefficient steps as identified in the mapping exercise. Strategies for improvement included:

- *Sorting applications into categories* to better organize work and improve staff efficiency by focusing on cases that are “ready to work.”
- *Creating new business systems to support technology and utilize automation* to help staff to spend their limited time more efficiently.

Lessons for Other States: Maximizing Enrollment states have learned important lessons from their experiences that are relevant to states considering the adoption of policies or practices with the purpose of simplifying application and enrollment procedures, especially with implementation of the ACA.

- **Use data to identify barriers to enrollment.** States found using different kinds of data from multiple sources, including enrollment and retention trend data as well as information solicited from stakeholder focus groups and surveys, can inform the state of barriers to enrollment.
- **Monitor progress of changes and adjust if necessary.** States found monitoring data helps to ensure that the program changes had the intended results.

- **Engage front line staff, community partners, sister agencies, and other stakeholders in the process of developing new policies or processes.** States benefited from early consumer input to help prioritize improvements and feedback from stakeholders post-implementation to learn how changes were being received.
- **Institutionalize improvements to protect them from changes in administration or priorities.** States can insulate simplification strategies from changing administrations by codifying the strategies in policy manuals and training programs.
- **Simplification and program integrity are not mutually exclusive.** States found they could maintain program integrity while eliminating barriers to enrollment by doing analysis to verify outcomes are consistent and by tracking trends over time.

Through their work before and during the grant period, the states that participated in the Maximizing Enrollment program improved enrollment and retention in Medicaid and CHIP by streamlining processes and simplifying policies. The following report shares the experiences of these states that may be considered models for states looking to expand coverage and improve systems to encourage convenient and efficient enrollment.

Introduction

In 2009, eight states received grants from the Robert Wood Johnson Foundation as part of the Maximizing Enrollment for Kids program to increase enrollment and retention of eligible children into Medicaid and the Children's Health Insurance Program (CHIP) and to establish and promote best practices in streamlining eligibility and enrollment systems, policies and procedures. With the enactment of the Affordable Care Act (ACA) in 2010, the Foundation expanded the goal of the program and renamed it Maximizing Enrollment: Transforming State Health Coverage to encompass state strategies to modernize eligibility, enrollment and retention policies to prepare for newly eligible individuals in 2014. During the four-year grant period, all Maximizing Enrollment program states made progress in simplifying and streamlining their eligibility, enrollment and renewal processes, including work focused on applications, eligibility determinations, renewals and transfers, notices and business processes. State teams identified areas for improvement, and, often through the support of the Maximizing Enrollment program, they implemented policy and system changes and additional reforms needed for ACA compliance in 2014. Inspiration for these simplifications came from the work of fellow grantees, ideas from internal and external stakeholders, analysis of enrollment data, and federal policy and experts providing technical assistance.

Strategies implemented by Maximizing Enrollment states during the grant period helped them pave the way for additional simplifications in two ways. First, in some cases Maximizing Enrollment states tested or modeled changes that all states are making to comply with new eligibility requirements under the ACA. For example, many Maximizing Enrollment states had implemented simplifications for children and families, like a streamlined application for Medicaid and CHIP enrollment, electronic verification, and administrative renewal, before the ACA was enacted. Second, many of these reforms are laying new ground for additional simplifications by modeling innovations or ideas that may smooth the path for other states.

This paper, the third in a series sharing Maximizing Enrollment states' work and lessons learned, focuses on these simplifications and how they are helping to pave a new way of thinking about eligibility and enrollment for state and federal agencies charged with managing enrollment into and retention in insurance affordability programs (Medicaid, CHIP, Basic Health Programs, and subsidized qualified health plans purchased through a health insurance marketplace). These strategies, which

were also in some cases pursued by other states, may be instructive as states look for ways to improve efficiency, lower costs, and promote responsible stewardship of limited public resources.

The simplifications described in this paper refer to the differences in the process for both state workers and individuals applying for coverage or enrolling in programs. For example, during a period when states experienced increased applications and reduced staff due to the economic downturn, states sought out ways to reduce staff burden of processing applications by simplifying or automating eligibility determinations. These improvements reaped rewards for management by improving staff morale, increasing the speed and accuracy of eligibility decisions, improving efficiency and realizing administrative savings for the program. Applicants and enrollees experienced these benefits in the form of speedier and easier enrollment, improved access to eligibility for coverage, and more effective communication with Medicaid or CHIP agencies with limited documentation requirements.

This paper explores work states did before and during the Maximizing Enrollment grant period and includes work done outside of the program to improve their programs. The paper begins with a discussion of the process states undertook to identify areas for simplification and the factors that motivated their actions and a brief overview of the ACA requirements that change the simplification landscape for all states. The paper then discusses five key areas of state simplification work: applications, eligibility determinations, renewals and transfers, notices, and business process improvements. Finally, the paper offers lessons states learned through Maximizing Enrollment work that may be useful as other states pave their own paths towards simplification in 2014 and beyond.

Background

State Pathways to Simplification

In 2009, the Maximizing Enrollment states participated in a “Diagnostic Assessment” to help each understand its strengths, challenges and opportunities in its effort to improve enrollment of eligible children. This diagnostic assessment generated information for each of the eight participating states to better understand their eligibility and enrollment policies and procedures. As part of this assessment, all Maximizing Enrollment states mapped out each step in their application and renewal processes, inclusive of all steps required by applicants, eligibility staff and systems. Once the teams could see all the steps laid out, they were able to identify unnecessary or duplicative steps to eliminate or figure out ways their systems could be improved to automate them. All states used findings from this and other elements of the diagnostic assessment to develop goals for their program work, but in particular many states cited the value of understanding current practice as a first step. Each state received an individual assessment report and findings from all eight states were summarized in an overview report. A major area of focus in the assessment reports was work related to improving eligibility, enrollment and renewal processes and to reducing paperwork for individuals applying for and enrolling in coverage and staff.¹

The diagnostic assessment found that “[s]tates have shown that taking steps to make the enrollment and renewal experience easier and more convenient for families can also lower administrative costs by introducing efficiencies that ripple throughout the eligibility system.” Nearly all participating Medicaid and CHIP programs had implemented several baseline policies prior to the start of the program, such as the elimination of face-to-face interviews and asset tests, some use of self-attestation or electronic data matches for eligibility information, and simplified renewals. The assessment findings also identified progress specifically, and often exclusively, in simplifying children’s enrollment to reduce the burden on families and staff. Despite the progress made in these specific areas, the evaluators recommended ways each state could either maximize the efficiencies it

had already implemented or implement new strategies to support the goals of improving processes and reducing paperwork.

While all states participating in Maximizing Enrollment used the findings of the Diagnostic Assessment reports as a foundation for creating specific improvement plans for their work over the course of the grant, other factors and priorities that influenced each state's journey towards simplification differed. Where some areas and ideas for improvement were identified internally through agency leadership and staff, progress also came in response to external inputs, such as legislative reports, results of customer surveys or focus groups, other stakeholder comments, or program data.

Legislative and Agency Influence. Illinois received a report from its legislature including mandates to improve enrollment and retention processes. Louisiana and Alabama agencies' identification that they would experience an increase in caseload and a simultaneous decrease in eligibility staff catalyzed the agencies to take immediate steps to sustain the operational viability by seeking greater efficiencies.

Consumer Feedback. In Alabama, Louisiana, and Utah, the state agencies received important inputs from focus groups or surveys with potential applicants and current enrollees. In Alabama, CHIP officials queried focus groups of program participants about their preferred method of enrollment and learned that using the telephone was not a preferred approach because it was perceived to be more time-consuming. Focus group participants reported that they preferred either paper or online enrollment. Alabama used this information to stage how they implemented the ACA's required options for enrollment, only using telephone renewals as part of their pilot testing work and saving full telephonic applications for later implementation due to the expected low utilization among consumers. Louisiana used focus groups to get feedback on enrollment and renewal processes and to test new paper and online application forms. Consumer feedback also led Louisiana to revise its paper application to make it easier to complete by adding more check boxes to replace open-ended questions. In 2010, Utah conducted focus groups and a survey. In 2012, Utah conducted a follow-up survey to measure progress. Questions covered application, renewal, denials, closures, as well as premium and cost-sharing requirements.

Stakeholder Engagement. Louisiana and Massachusetts also solicited feedback from other stakeholders. Louisiana sought inputs from eligibility workers through a staff survey, followed by focus group discussions. Through these engagements, the state heard concerns from eligibility workers about the effect of recent office closures and got input on significant policy and system changes. Massachusetts conducted focus groups with community outreach workers to get a baseline understanding on operational barriers to retention. The focus groups confirmed what state officials already knew from existing data and member feedback—that retention should be a priority area for change. In this way, the focus groups affirmed an area of priority for state work.

Data Analysis. Throughout the grant period, Maximizing Enrollment states were also strongly influenced by data. States were able to use enrollment and retention data that was collected, cleaned and analyzed by Mathematica Policy Research, the evaluator for the program. The ability to track trends over several years in enrollments, denials, disenrollments and other variables enabled states to target areas for improvement and identify specific solutions. Additional detail on how each state's leadership identified programmatic priorities and how the state responded can be found in *Managing Program Change: Experience from Maximizing Enrollment States in Leadership, Culture Change, Coordination, and Data*, released in December, 2013.²

Peer Learning. Maximizing Enrollment states also learned, and were influenced by what they learned, from other participating states. Although Maximizing Enrollment states' knowledge transfer extended beyond streamlining and simplification work, states were particularly active and engaged in learning new simplification strategies and ideas from each other. For example, Utah's state team reported that it had based its simplified renewal policy on Louisiana's successful use of administrative renewal for enrollees with low risk of losing income eligibility from year to year. Louisiana's automated Express Lane Eligibility process also inspired Massachusetts and Alabama Medicaid to implement similar processes. The team from Massachusetts reported that it considered participating in the Maximizing Enrollment program itself key to changing its state's thinking about its processes.

ACA's Simplification Mandate

The passage of the ACA and subsequent guidance mark an unprecedented moment in federal support for program streamlining and simplification. The law provides for expanded coverage and improved systems to encourage convenient and efficient enrollment. It also includes provisions designed to aid states as they streamline and simplify their programs, without which they would likely find the new coverage requirements more burdensome to implement. Streamlining requirements included in the ACA and flexibility offered to states by the Centers for Medicare and Medicaid Services (CMS) will change the way states and families experience application and enrollment into Medicaid and CHIP.

The new law validates and incorporates much of the progress states have made in Medicaid and CHIP through optional policy and procedural changes, including those implemented as part of Maximizing Enrollment. These simplifications will change fundamentally the way states do business.³ Some of the major provisions included in the law that will contribute to the new simplified and streamlined processes are:

- Simplified Application Process
 - Streamlined, single model application that can be submitted online, by phone, by mail or in-person
 - Elimination of face-to-face interview requirements for most applicants
 - Expansion of presumptive eligibility to new populations and a new option for hospitals to utilize presumptive eligibility
- Administrative Verification of Eligibility
 - Self-attestation requirement for pregnancy and self-attestation options for other eligibility requirements
 - Eligibility determinations using available electronic data rather than paper documentation
 - Changes in household income determination, including movement to a standard modified adjusted gross income (MAGI) calculation with a 5 percent disregard and tax-based household calculation for certain non-disabled, non-elderly groups
- Simplified and Coordinated Notices
 - Plain language, accessible notices that are coordinated among coverage programs and provided to consumers electronically if preferred
- Streamlined Renewal Process
 - Mandatory 12-month renewal period
 - Use of available data to renew eligibility without requiring forms or signature, and mandatory use of pre-populated forms for administrative renewals without signature for individuals where more information is needed.

Additional Flexibilities for States

In addition to the ACA requirements cited above, CMS released guidance on May 17, 2013 offering states options to streamline and simplify their eligibility processes to ease the burden on enrollment systems during the first two years of implementation by using five temporary targeted enrollment strategies:

- Adopting MAGI-based rules as of October 1, 2013 rather than waiting until January 1, 2014.
- Extending renewal periods beyond the first quarter of 2014 when MAGI-based renewals will begin to be required.
- Using other means-tested program administrative data (e.g., SNAP income data) to enroll adults and children into Medicaid.
- Using children's income eligibility to enroll parents.
- Extending 12-month continuous eligibility for enrolled adults.

All strategies are available to states on a temporary basis and require waivers to implement. The first and last require an 1115 waiver and the remaining strategies require a 1902e waiver. As of January 29, 2014, 32 states and the District of Columbia were approved to implement at least one of the targeted enrollment strategy options, with the greatest number of states (30) taking up the option to extend renewal periods, 15 states taking up the option to implement MAGI rules before January 1, six states taking up the option to facilitate enrollment through administrative data, and four states taking up the option to enroll parents based on child eligibility. No states have yet taken up the option to extend 12-month continuous eligibility to adults. Three of the Maximizing Enrollment states (Illinois, Louisiana, and Virginia) have implemented at least one of the targeted enrollment strategies, with all implementing early implementation of MAGI, Illinois and Louisiana implementing the extended renewal periods and Illinois implementing using SNAP data to enroll adults and children.

Source: CMS Targeted Enrollment Strategies Tracking Chart (downloaded January 29, 2014 from <http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Targeted-Enrollment-Strategies/targeted-enrollment-strategies.html>)

Key Areas of State Work

Though the pathways leading to states' adoption of policy and process simplifications varied, the improvements they pursued before and during the Maximizing Enrollment program can be grouped into five areas: (1) applications; (2) eligibility determinations and enrollment; (3) renewals and transfers; (4) notices; and (5) business process redesign. Often, these strategies complemented efforts to deploy technologies to streamline application and renewal simplifications, customer interfaces, system functioning and workflow management. More detail about states' use of technology can be found in the report *Harnessing Technology to Streamline Enrollment: Experience from Eight Maximizing Enrollment Grantee States*. The strategies Maximizing Enrollment and other states tested, some of which are now part of the ACA's requirements for all states, provide positive models for states committed to increasing enrollment in public health coverage while reducing administrative burden on staff and eligible families. This section provides more detail on key areas of state work in each of the five areas.

Applications

Maximizing Enrollment states considered changes to their application forms and procedures against a backdrop of major changes precipitated by the ACA. As noted above, the ACA requires all states to adopt a single streamlined application for all insurance affordability programs (IAPs), including Medicaid and CHIP, and for tax credits and cost-sharing reductions for qualified health plans purchased through a health insurance marketplace. States are required to either use the model application or obtain approval from the Secretary of Health and Human Services to use an alternative version.⁴ The ACA also requires that states permit applicants to submit the applications online, by mail, or over the phone, as well as in person. State IAP agencies must also provide a “no wrong door” approach to application processing through which an applicant can submit an application once to any IAP to be seamlessly determined eligible for coverage for whatever program he or she is eligible without submitting additional information.⁵

Although much of states’ work during the grant period was focused on transitioning applications and processes to comply with ACA requirements, a few states implemented application reforms during the program that were similar to ACA requirements or demonstrated additional steps other states may want to consider for post-ACA simplifications. Examples of state application and related simplifications include:

- *Combining Medicaid and CHIP Application and Renewal Forms:* Utah tested the work needed to simplify application forms by creating a single form that could be used for both Medicaid and CHIP and standardizing application, determination and renewal processes for both programs.
- *Scanning/Uploading Verifications Electronically:* Wisconsin updated its online application system to allow applicants to scan and upload their verifications electronically. In this way, the state innovated and used technology that will enable maintenance of verifications submitted by applicants electronically as part of the electronic case record system. Virginia implemented functionality to allow individuals to upload verification documents for CHIP applications in 2010.
- *System Interfaces That Reduce Processing Burdens:* Louisiana implemented two application system changes to make the process work more simply, for applicants and state workers. First, the state created an auto-generated confirmation message to send to applicants that have successfully completed and submitted their applications. Second, the state created back-end system connections so that information keyed into the online application automatically populated an eligibility system case record. Before this change, state workers had to manually re-enter data from online applications, which was burdensome and time-consuming.
- *Seeking User Inputs to Streamline Applications:* Both New York and Louisiana sought inputs from end users of their applications (both consumers and those who assist consumers) to simplify language and better understand burdens in the application process. While some of the changes the states considered will likely be displaced given new ACA application requirements, the process of seeking inputs from end users was considered very valuable by both states’ teams and may be a good model for other states to replicate as they proceed with implementation of new applications.
- *Eliminating In-Person Application Requirement:* During the grant period, New York eliminated its in-person interview (also known as a “face-to-face” interview) requirement as a way of reducing barriers to enrollment for adults applying for Medicaid. As part of their process for changing application requirements, New York redesigned its application to allow consumers to include additional information on the application that would be needed to make an eligibility

determination. Some of this information had previously been obtained during the face-to-face interview. The application was also redesigned to better enable consumers to complete and submit their applications on their own. Although the state sought to make the application easier for consumers to use without assistance, New York also maintained its diverse network of thousands of facilitated enrollers to assist consumers who need help with the application process. In 2014, all states will be required to eliminate their in-person interviews and implement the model streamlined application or an alternative application for MAGI groups. New York's experience with redesigning its application may be of interest to other states undergoing similar changes.

Eligibility Determinations

As a complement to their work on application forms and processes, a number of states made improvements to eligibility determination processes. Most of states' work focused on strategies to reduce the burden of processing applications to allow eligibility staff to manage larger caseloads more easily, efficiently, and accurately. These strategies were also targeted to improve consumers' experience of the eligibility determination process, making it simpler for eligible individuals to be enrolled, even in cases where those eligible for coverage hadn't yet applied. While states considered and implemented numerous smaller procedural changes, two simplification strategies had a significant impact on state eligibility processes: Express Lane Eligibility and Automated Newborn Enrollment. Maximizing Enrollment states' experience with both of these strategies offers models and lessons that may be useful to other states considering implementing these or related strategies

Express Lane Eligibility (ELE)

Express Lane Eligibility is an enrollment simplification strategy enacted into law in 2009 under the Children's Health Insurance Program Reauthorization Act (CHIPRA), which gives states the option to borrow an eligibility finding from another program to enroll eligible children in Medicaid and CHIP.⁶ Using ELE, the state can leverage information it already has from other human service programs and other data sources to identify children who are eligible but not enrolled. This strategy was designed to both reduce the state's administrative burden and make it easier for vulnerable children to enroll in coverage by allowing them to be determined eligible based on documentation the family already provided to the state.⁷ While ELE is statutorily limited to enrollment of children, CMS has approved two states to use ELE for enrollment or renewal of adults through Section 1115 demonstration waivers granted to Massachusetts in 2011 and Alabama in 2012.⁸ For states that are operating their ELE processes under the state option provided under CHIPRA, this option is slated to expire on September 30, 2014 unless it is statutorily extended.

Five Maximizing Enrollment states (Alabama, Louisiana, Massachusetts, New York and Utah) implemented ELE during the grant period, using the strategy to streamline enrollment and/or renewals of children and/or adults into Medicaid and CHIP. Using the flexibility afforded through CHIPRA, each state designed their ELE strategy differently. States use ELE in the following ways:

- *Identifying Those Eligible for Health Coverage, but Uninsured:* Essentially, using ELE in this way is a targeted outreach method with a very streamlined application. Medicaid or CHIP uses data from an Express Lane Agency (ELA)⁹ to identify individuals enrolled in that particular ELA program that are not enrolled in health coverage. The health program then sends those individuals shortened applications for coverage that usually only require a signature to consent to enroll in Medicaid or CHIP. While individuals still need to return signature pages, they generally do not need to send additional eligibility information because Medicaid or CHIP is

using the data from the ELA and verifies citizenship through data exchange with the Social Security Administration.

- *Simplifying Eligibility Procedures:* ELE can minimize manual processes for staff by reducing necessary procedures to determine eligibility. Alabama's ELE strategy has evolved over time, but started in 2009 by requiring an eligibility worker to manually check the SNAP or TANF systems to verify if an individual was enrolled in either program. If an individual was active in either SNAP or TANF, the worker noted it in the case file and did not need to verify the individual's income saving staff time and minimizing documentation from the individual. By 2012, renewals were automated through ELE totally removing worker or client input. New York used ELE to simplify procedures in transitioning children from CHIP to Medicaid at renewal without requiring more information from the child's family.¹⁰
- *Automating Enrollment and Renewal:* Relying heavily on technology, this version of ELE allows different programs to share data between their systems daily without requiring worker intervention. Louisiana pioneered this method of ELE, which has evolved over time, to now support the state's SNAP program to add children found eligible for SNAP (whose families consented to share their information by checking a box on the SNAP application) into Medicaid's system each night. Medicaid accepts SNAP eligibility determination and only needs to verify the child's citizenship, which is also done on a daily basis through a data exchange with the Social Security Administration.

As a result of Maximizing Enrollment resources—grant funds, technical assistance, and peer-to-peer learning—these five states have been leaders in designing and implementing ELE, including in innovating automated enrollment and piloting ELE for adult populations. As leaders, these states faced implementation challenges that included interfacing separate eligibility systems that collect data in different ways; entering into memorandums of understanding to share information; and in some cases working with new partners to implement an untested strategy. Even considering the challenges of implementation, states report a number of benefits from implementing ELE. Louisiana credits ELE with saving the state 69,000 staff hours, which is the equivalent of 33 full-time staff, during the recession when budget cuts resulted in fewer staff during a time of high demand for Medicaid.¹¹ Alabama reports using ELE for 43 percent of the state's Medicaid renewals, which allows staff to devote time to more complicated cases.¹² Consumers also benefit from expedited eligibility reviews because documentation is not required.

Automated Newborn Enrollments

Virginia and Louisiana have both implemented automated newborn enrollment into Medicaid (and CHIP in Virginia), a process pioneered by Oklahoma.¹³ This process takes advantage of one of the most clear-cut Medicaid eligibility rules as well as easy access to the targeted population. Children born to mothers enrolled in Medicaid or CHIP are, in all cases, "deemed" to be eligible for Medicaid as well.¹⁴ Since Medicaid covers a significant number of births, automating enrollment into Medicaid can relieve a lot of administrative burden and secure coverage without gaps or administrative hassles for children during their critical first year.

Through partnerships with hospitals in Virginia providing delivery services to mothers, newborns can be sent home with an approval letter and ID number. This process is supported by existing technology. Instead of completing a paper form and mailing it to the local office, the hospital can complete an on-line form with minimal data about the newborn and mother and receive the approval letter with ID number through a secure email within one to two business days of submission. Though the eligibility card and notices follow, the mother can use that ID card immediately for follow-up care.¹⁵

If the mother was enrolled in a managed care plan at the newborn's birth, the baby will be automatically enrolled in the mother's plan as part of the expedited process.

In Louisiana, hospital staff can access the Newborn Automation System, which it uses to enter information on babies born to mothers enrolled in Medicaid. The system verifies the mother's information, certifies the newborn's coverage, creates an entry in the electronic case record, and generates a notice to the family without the need for intervention by staff.¹⁶

Renewals and Transfers

Renewals and program transfers can pose greater workload challenges to states than applications, due to the volume and frequency managed by the state throughout the year. In Louisiana, a pioneering state in its focus on renewals, state officials reported that they viewed their focus on renewal strategies as a means to achieve a greater return on investment from the initial enrollment process. When an enrollee loses coverage at renewal for a reason other than being ineligible, for example due to a renewal form not being returned or nonpayment of premiums, he or she often reapplies within a few months. This repeat application and enrollment process, also known as "churn," is burdensome to both the family and eligibility staff because of the need to complete and process a new application, which is generally more time-consuming and complex than a renewal process.

The risk of churn also exists for program transfers, which occur when enrollees' eligibility status changes during the year, creating eligibility for a new coverage program. For many states, program transfers have historically not been seamless in operation. Even in states where data from a newly eligible individual is transferred from the Medicaid to CHIP agency and the state is obligated to screen and enroll the child into the proper coverage program, the process has been slow, was often paper-based, and in the worst cases required individuals to fill out a new application to be enrolled. When individuals whose data the state already has are forced to reapply to be enrolled, the process can lead to unnecessary gaps in coverage, accidental disenrollments, increased workload for staff, and increased burden and loss of continuity of coverage or care for enrollees. Given the volume of cases involved and the risk of repeat work posed by churn, states that prioritize simplifying renewal and transfer processes can realize significant administrative savings, improve consumer experience, and increase longevity of coverage for eligible individuals.

All states in the Maximizing Enrollment program made strides in simplifying their renewal processes to increase retention in Medicaid and CHIP programs during the grant period. Maximizing Enrollment states worked to reduce the burden of renewals on both families and staff and minimize churn by: (1) minimizing enrollee submissions to complete renewal; (2) lengthening renewal periods; and (3) making it easier to pay premiums at renewal. Minimizing loss of coverage by smoothing agency handoffs during program transfers was an area of focus during the grant period for Alabama and New York.

Even as the ACA requires states to lessen the burdens on enrollees by using information states already have to process renewals and requiring seamless transfers of enrollees' accounts among insurance affordability programs, the increased volume of cases expected to flow through state agencies raises the stakes for states getting these strategies right. In this context, the Maximizing Enrollment states' experience may offer additional models and strategies for states to consider as implementation moves forward.

Minimizing Enrollee Submissions

Maximizing Enrollment states honed existing strategies and developed new ones to leverage information the state already had about enrollees to renew their coverage, including by institutionalizing ex parte renewal policies, implementing administrative renewal using prepopulated forms, developing new administrative renewal strategies, and using tax and other program data to renew using express lane eligibility.

Ex parte renewals use data the state already has to conduct a renewal determination. With ex parte renewals, states use data from sister agencies or other available income verification sources to either complete the renewal determination or to verify data provided on the application. Virginia was already using ex parte renewal for children in their Medicaid program, but discovered through focus groups with eligibility staff that employees were not applying the policy consistently. According to the focus group findings, while some workers were using it well, others didn't understand that they could use it or when they should. To clear up misconceptions about how and when ex parte renewals could be used, Virginia's Department of Medical Assistance Services (DMAS), the state Medicaid agency, updated the policy manual and released it to all staff. DMAS also conducted training to better educate staff on the policy and how to use it.¹⁷

Administrative renewals, whereby a state uses data it already has to prepopulate renewal forms and send them to enrollees for review and completion, is a strategy that was used by six Maximizing Enrollment states to minimize submissions for renewal. In lieu of requiring clients to complete new renewal forms every year, Alabama and Virginia CHIP used prepopulated forms that drew from information on file. In 2010, Virginia added income data and allowed renewing enrollees to self-attest for CHIP renewals.¹⁸ This administrative renewal process is similar to the required process all states will have to use for most renewals under the ACA beginning in 2014. Under the ACA, all states will have to renew coverage using data sources the state already has and, if insufficient data exist, create a prepopulated renewal form that will be sent to the enrollee for review and completion.¹⁹

Louisiana implemented a different type of administrative renewal strategy under which a state uses available data to identify groups of Medicaid-eligible individuals whose incomes will remain constant over time. These individuals may be disabled children, elderly individuals, disabled adults, or dual-eligible individuals whose sole income is from Social Security retirement or survivor or disability benefits. Because government benefits provide their sole or major source of income on an ongoing basis, the state determined that there is no need to require them to continue to submit documentation of income every renewal period. Once the state identified groups of individuals that met the states' criteria for static income, the state sent a notice to these individuals that they would be renewed periodically and now sends notice at every renewal period to update the state if income or eligibility status has changed.²⁰ It is important to note here that the annual renewal process generally still involves affirmative verification of income using available data from federal and state benefit program sources, but because no additional information is generally required from the individual, the state can automatically renew without additional paperwork.

Louisiana, Massachusetts, and Wisconsin all implemented administrative renewal during the Maximizing Enrollment grant period.²¹ As noted in another Maximizing Enrollment report, *Managing Program Change*, Louisiana saw the most significant caseload impact of implementing this strategy. By the end of 2010, Louisiana reported that it had processed 288,000 cases, equivalent to the workload of 160 full-time enrollees and saved \$8.25 million annually.²² Using a strategy like administrative renewal that identifies individuals that are likely to be continuously eligible for coverage and automating their renewal process to the greatest extent possible could significantly lighten states'

administrative caseload in 2014 and future years. Especially given the increased, real-time access to federal data sources through the federal services data hub, this seems a promising and viable strategy for most states that could increase continuity of coverage for vulnerable low-income enrollees and reduce administrative costs for stretched state eligibility resources.

As noted above in the Eligibility Determinations section, a number of states implemented ELE strategies to leverage other program data to determine or renew eligibility for children and adults in Medicaid and CHIP. Although most states typically rely on other program's income data, Utah developed a partnership with the Utah State Tax Commission to allow clients enrolled in CHIP to approve the use of their adjusted gross income from their most recent state tax form as documentation of income for renewals without additional intervention by eligibility staff. Families must first sign a form authorizing the use of this information. Despite some promise of promoting simplification for CHIP-enrolled families, it is not widely used by enrolled families. On average, only about 95 cases (about 0.3 percent of Utah's monthly caseload) are using adjusted gross income (AGI) for verification at renewal each month.²³

Lengthening the Renewal Period

Another way to reduce the burden of renewals is to lengthen the period of time between recertification. States can accomplish this in a number of ways, including through lengthening renewal periods to one year, which is a requirement for all states under the ACA effective January 1, 2014.²⁴ In addition to simplifying the renewal process and improving retention, moving to a standard annual renewal under the ACA will further align Medicaid, CHIP, and the exchange as all insurance affordability programs must be renewed no more than once per 12-month period. If a beneficiary in any of the IAPs informs the agency of a change in circumstance or the agency becomes aware of one, a renewal (and program transfer if appropriate) must be processed at that time.²⁵ By the end of the Maximizing Enrollment grant period, all Maximizing Enrollment states were using a 12-month renewal period for children.

Another strategy that a number of states were using to lengthen renewal periods as a pre-ACA simplification strategy was off-cycle renewals. Off-cycle renewal is the practice of completing a renewal at another point of contact with the state during the enrollment period before the regularly scheduled renewal date. For example, if a mother calls to report a new child in the household, the worker can get some basic information, update the case and extend the renewal date for another enrollment period. Some states allow for off-cycle renewals to be triggered by a visit to a provider and involve the provider in completing the renewal for the patient. Off-cycle renewal can encourage enrollees to report changes and, if the state has a 12-month continuous eligibility policy in place, there is no risk to the early renewal. Using off-cycle renewals can help states stagger the workload associated with renewing cases in a situation when most enrollees signed up in a given month. Off-cycle renewals can also improve efficiencies for states and enrollees by taking advantage of the contact with the state and completing the re-enrollment at the moment when the enrollee is available and in communication with the state.

Massachusetts piloted a form of off-cycle renewal as part of a telephone review pilot project.²⁶ Under the pilot, enrollees who had not had an annual review in 10 months or longer, including members whose cases were closed for failure to return an annual review form were eligible to have their cases renewed over the phone by an eligibility worker taking incoming calls. If an individual who met the criteria called in for assistance, the eligibility worker would help the person to complete an annual renewal over the telephone without requiring submission of any forms. The state undertook the pilot to test implementation of phone renewals under the ACA, but also found the off-cycle simplified renewal

option had a positive impact for eligible participants and workers. Many of the enrollees participating in the pilot had already lost coverage due to a failure to submit a renewal form. Examples included a blind woman who suffered from epileptic seizures and had been calling to ask for an extension on her review form because she was unable to complete it. She had her review completed over the phone and was referred to MassHealth's disability ombudsman to request future notices in Braille. Another enrollee who participated said he "felt like he won the lottery" because he wasn't being required to submit additional forms to renew coverage. The process also provided advantages for the state by allowing eligibility workers to resolve cases as individuals called in, rather than requiring ongoing administrative review and delays.

While off-cycle renewals could provide a powerful tool for states to lessen administrative burdens of renewal after the ACA is implemented, it is unclear whether the new 12-month renewal period requirement under the ACA restricts states from using this tool. States will want to obtain counsel from CMS about whether this strategy can be used to support renewal simplification after January 1, 2014.

Premium Payment Methods

Premium payment is another process that states can simplify to reduce churn. Though not necessarily a method of renewal, nonpayment of premiums results in a loss of coverage and is a major factor driving disenrollment of eligible individuals. According to a Georgetown University Center for Children and Families survey conducted for the Kaiser Commission on Medicaid and the Uninsured, all states that charge premiums for children's coverage terminate coverage if premiums are not paid. Some states allow grace periods in which individuals can retain coverage for a period of time after nonpayment, with most states allowing between one and two months and one state, Maine, allowing for a 12-month grace period. Furthermore, 12 states require a lock-out period when an individual who doesn't pay premiums must be disenrolled from coverage. State lock-out periods historically range between one and six months before the coverage can be reinstated after being terminated for nonpayment.²⁷ However, the ACA limits states' authority regarding grace periods and the imposition of lock-out periods. First, guidance issued by CMS in July 2013 requires states to provide a 60-day grace period for payment of any premiums and clarifies that lock-out periods are not permitted for Medicaid enrollees for nonpayment.²⁸ In addition, states are limited to imposing lock-out periods of no more than 90 days for nonpayment of premiums and must reinstate coverage upon payment.²⁹

With more advanced eligibility systems, states have been able to expand functions beyond just application and renewal and make processes such as premium payment easier. In fall of 2011, Louisiana began allowing bank draft and credit card payments for enrollees in the LaCHIP Affordable Plan, the state's program for higher income CHIP enrollees, which charges a \$50 monthly premium. The state reported that under the new system 30 percent of beneficiaries pay by bank draft and 20 percent pay by credit card. While the new options have not had an obvious effect on the rate of closures due to non-payment, the options are popular with enrollees.³⁰

With an expected increase in the number of individuals applying for public coverage programs and increased eligibility under Medicaid in more than half the states in 2014, states looking to lessen the burden of the renewal process may want to consider additional premium payment simplifications, including simplifying the methods of payment, providing for annual payment periods, or other strategies.³¹

Program Transfers

Families enrolled in Medicaid and CHIP often have volatile incomes and their eligibility for the programs can change over the course of a year due to income fluctuations or changes in household composition that impact eligibility status. Those transitioning from one program to another are particularly vulnerable to losing coverage altogether. While children enrolled in Medicaid or CHIP in states with a policy of 12-month continuous eligibility are protected from mid-year program disruptions, parents and other enrollees, for whom 12-month eligibility is not a statutory option, can benefit from smooth transitions. Streamlining this process requires coordination between agencies, particularly in states with a separate CHIP program where different agencies historically have managed eligibility determinations for Medicaid and CHIP. Maximizing Enrollment states made progress in smoothing program transfers to minimize coverage disruptions by employing several strategies to improve their communication and data transfers between agencies.

The Alabama Maximizing Enrollment team utilized grant resources to improve transfers between Medicaid and separate CHIP programs by automating some of the information transfer between the two program agency systems. Alabama's Medicaid agency is also preparing to automate transfers of children enrolled in Medicaid due to participation in the foster care program into a former foster care eligibility group when they age out of Medicaid coverage as foster care children, in compliance with new ACA requirements. In May 2012, New York implemented Express Lane Eligibility to smooth the transition of eligible children between the separate CHIP and Medicaid programs at renewal due to a drop in family income. Children whose CHIP renewal form is submitted along with documentation or attestation of household income that is too low for CHIP are coded as "ELE" and transferred to Medicaid. (The renewal must also include the Social Security numbers of the household wage earners.) The Medicaid office accepts the CHIP income finding and automatically enrolls the child into Medicaid without any gap in coverage or additional documentation.³²

In both of these states, state agencies have explored new methods to retain eligibility at program transfer by increasing capacity to electronically transfer eligibility information and borrow eligibility findings from another program or determination process.

With the implementation of the ACA effective January 1, 2014, all states will be required to effectuate electronic account transfers among all insurance affordability programs. This will increase the stakes for states to perfect seamless program transfers to minimize churn among enrolled individuals resulting from eligibility changes.

Notices

Regardless of the policies states implement to streamline enrollment, renewals, or program transfers, the states are required to communicate program information with their enrollees on a regular basis. State Medicaid and CHIP agencies send notices to inform applicants of their approval or denial of coverage; to request additional information; to inform them of an upcoming renewal date; and many other more complicated scenarios. Often eligibility systems or separate notice systems that communicate with the eligibility system generate these notices automatically by plugging in relevant, prewritten text according to codes provided by actions made on the case. Because these notices have to convey complex information and can be brought up in appeals hearings, program leadership and legal departments play a big role in the development of notice language. These factors can lead to

notices being confusing to the applicant or enrollee receiving the notice, which creates barriers to successful eligibility communication if the notice requires action.

Massachusetts's Maximizing Enrollment team initiated work on updating notices that were hard for enrollees to understand and use. The old notices were long, used complex language, were confusing, and used only one font with little white space, making them hard to read. Working with the MAXIMUS Center for Health Literacy, Massachusetts undertook a notice redesign project to improve notice language, feel and design. As Massachusetts was initiating this project, the state was also building a new ACA-compliant eligibility system that included a new notice system. In the spring of 2012, the state combined the Maximizing Enrollment work with the ACA-funded system development work. The state held a kick-off meeting including legal, policy, and system staff as well as external advocates. According to team staff, getting everyone on the same page was critical to the team's efforts to align redesign goals and think through concepts. The group drafted an initial set of 12 basic notices based on model types, shared drafts for comment, and ultimately field-tested 5 notices in different environments to determine how well they were understood. Ultimately, Massachusetts emerged from the process with 175 improved notices by the end of 2013. Massachusetts reported that getting support to design accessible, plain language notices and engaging in the field-testing process were both highly valuable.³³

Notice redesign is a process that most states are likely engaging in as they implement the ACA's requirements in 2014 and future years. The ACA requires that all states make notices more understandable, accessible, and easier to navigate for consumers. Under the ACA, all notices from insurance affordability programs (IAP) must, to the greatest extent feasible, be combined into a single notice. Notices must include clear and specific content explaining the reason for any action (e.g., denial or disenrollment). Notices must be written in plain language and be accessible to individuals with disabilities and those with limited English proficiency.³⁴ CMS has issued a set of model notices for states to use in redesigning their own notices. In addition to the content provided in the model notices, states may also want to consider replicating a stakeholder engagement process like the one Massachusetts used to ensure that all stakeholders are invested in and provide input to the notice process and use field-testing to ensure notices are understood by the target audience.

Business Process Improvement

Another critical area of Maximizing Enrollment state work to streamline and simplify eligibility policies, procedures and systems was their effort to make business processes simpler, more rational, and consistent with new technological updates. This business process work took a variety of forms, including analytical efforts to identify barriers or opportunities for simplification, addressing processing barriers in practice, and creating new business systems to support new technology. Examples of each are provided below.

As noted in the Background section above, all states participating in Maximizing Enrollment participated in a diagnostic assessment process that included mapping their business processes for enrollment and renewal procedures. These "maps" included information about handoffs and timeframes for each step and identified barriers or redundancies in the process. States found this process very useful to their efforts to identify simpler business processes. To support other states' use of similar processes, NASHP created a self-assessment toolkit that includes a process-mapping exercise and instructions that may remain a helpful tool for states seeking to identify strengths and challenges in enrollment and retention processes.³⁵ For example, New York officials utilized process mapping that drew on their experience with process mapping from Maximizing Enrollment to begin designing the new system they built to comply with the ACA.³⁶

Using Maximizing Enrollment technical assistance resources, the Illinois Maximizing Enrollment team identified the cause of an application backlog and developed a strategy to overcome it. Due to Illinois' caseload backlog, it took analysts over 45 days to process an application. With Maximizing Enrollment-sponsored technical assistance from the Southern Institute for Children and Families, the state reviewed data looking at the current situation, and then identified and implemented a solution. Under the new plan, the team sorted applications into three categories: older applications that were part of the backlog, new applications that were ready to be processed, and new applications that needed additional information before they could be processed. The state then broke eligibility workers into groups and assigned one group to work each of the three categories.³⁷ Using this "ready to work" approach allowed workers to focus their energy on eliminating the backlog and at the same time speeded processing for the majority of applications that were ready to be processed. After a month of following the "ready to work" model, the team had eliminated the caseload backlog and reduced application-processing time from 45 days to a low of four days.³⁸ Although the state wasn't able to sustain the processing outcomes due to redirection of staff, the model is a powerful example of how a close examination of business processing systems and creating rational models can have a powerful impact.

Alabama's Maximizing Enrollment team also worked to implement a "ready to work" triage system in select Medicaid offices. Under Alabama's proposed change, staff would work first on applications ready to be processed quickly before moving on to cases that need additional information from applicants. While the change has the support of leadership, they have found that implementing such a change is challenging and requires a change in the culture of eligibility staff to be successful.³⁹

Utah is an example of a state that created a new business process designed with the eligibility system in mind. After Utah implemented its new electronic eligibility system, eRep, the state created a system called the Customer Full Kit to support eligibility worker engagement with the new system. The Customer Full Kit, which was created during the Maximizing Enrollment grant period but not funded by the project, alerts eligibility staff when an applicant has provided all the verifications and the application is ready to be worked. Utah's team reports the Customer Full Kit system helps staff to spend limited time more efficiently.⁴⁰

Most states are implementing new systems and processes as part of ACA implementation. To ensure these systems and processes work well, states may want to engage leaders and workers in some exercises to ensure that the processes are efficient, rational, and streamlined to eliminate unnecessary steps and quickly accomplish intended outcomes.

Lessons for Other States

The Maximizing Enrollment program coincided with a tumultuous five years for state health coverage. Through their grant work and interactions with stakeholders and fellow states, Maximizing Enrollment states learned lessons that may be helpful to colleagues considering ways to simplify and streamline their policies and processes. While some lessons will be relevant specifically to the implementation of the ACA, others are worthy of consideration by states regardless of changes in federal or state policy.

Use data to identify barriers to enrollment: The states participating in the Maximizing Enrollment program had the benefit of access to application and enrollment data analysis provided by Mathematica Policy Research, which served as an evaluator for the program. However, all states can collect and analyze data to identify barriers to enrollment or renewal for their clients. While access to

the person-level data provided to Maximizing Enrollment states during the grant period may go beyond what states may currently maintain, federal funding for new or improved eligibility systems provides an opportunity for states to consider their data needs for this new environment and build regular collection into their new systems. In addition, new federal data reporting requirements create opportunities for learning that states can leverage to improve internal program management. Data states gather from focus groups, surveys, and other interaction with stakeholders are also helpful in identifying areas where states can streamline processes or make policy changes that will eliminate barriers to enrollment or renewal. Several Maximizing Enrollment states sought out this information from their enrollees, potential applicants, or eligibility staff and were able to gain information about how they experienced the program, and where they experienced difficulty navigating enrollment and renewal. Though data collection and analysis can be time and resource intensive, Maximizing Enrollment states often found the benefit to the program and its beneficiaries made the engagement worth the effort.

Monitor progress of changes and adjust if necessary: Once states invest the time and energy into their data collection, they can monitor their progress over time. It is important that states continue to monitor the results of implementation to ensure that their changes have had the intended result. Maximizing Enrollment states found in several cases that simplifications can require additional adjustments to achieve the promise of making the process easier for consumers. For example, New York found that eliminating face-to-face interviews, and thus eliminating consumer assistance interaction with the caseworker, required the state to redesign the application to get additional information and maintain consumer assistance to ensure that those who needed assistance would receive it. States will want to monitor inputs from consumers and assisters to be sure that their proposed simplifications are having the intended effect and make adjustments as needed along the way.

Engage front-line staff, community partners, sister agencies, and other stakeholders in the process of developing new policies or processes: Throughout the course of the grant period, states found the benefit of input from the actual users of the systems and processes they implemented. This input is vital before implementation and can be a valuable source of information after implementation to inform policy-makers about how changes are being received in reality. Through focus groups with enrollees, Alabama CHIP found that telephonic applications were less-preferred and learned the reasons why. While the state appreciated and considered this information, passage of the ACA required states to provide this method of application to consumers. Because this information had been solicited prior to developing telephonic application policies and procedures, having this input ahead of time saved some effort in implementing the policy effectively and allowed it to be placed lower on their priority list for implementation.

Institutionalize improvements to protect them from changes in administration or priorities: All states experience change in administrative priorities over time, whether they are due to changes in leadership or the result of outside forces such as federal or state policy changes. To some extent, however, states can work to insulate simplification strategies from these changes by institutionalizing them or their processes at the time they implement them, for example, by codifying simplification strategies in policy manuals and training programs. Louisiana provides a good example of a state that has worked to institutionalize changes to continue momentum towards simplification and organizational culture change system-wide.

Simplification and program integrity are not mutually exclusive: A common concern states have when streamlining and simplifying their programs is how changes will affect program integrity. The

goal of the Maximizing Enrollment grant program was to increase enrollment and retention but only for those eligible for the programs. The states participating in the program found that they could maintain the integrity of their programs while removing barriers to entry by doing back-end analysis to verify outcomes were consistent with program integrity and to track trends in enrollment over time. Louisiana, for example, is comfortable with the risk involved with their administrative renewal process because of the analysis they did to identify exactly which types of cases were least likely to have significant changes in eligibility and their back-end audit of caseload outcomes, which indicates a low error rate. Louisiana also boasts a low payment error rate, as measured by federal audits, thus affirming the idea that program simplification and program integrity can happily co-exist.

Conclusion

Through their work before and during the grant period, the states that participated in the Maximizing Enrollment program worked to improve enrollment and retention in Medicaid and CHIP by streamlining processes and simplifying policies. The teams concentrated on five major areas: applications; eligibility determinations; renewals and transfers; notices and business process improvement. As a result of their work, families in each of the states may now experience improved clarity and speedier decisions when interacting with public health coverage programs. Additionally, eligibility staff is able to manage their caseloads with greater efficiency and accuracy.

Along with major changes in federal policy during the course of the grant, states identified areas for improvement through input from stakeholders. Often they solicited input from users after implementation as well in order to check in on progress. Maximizing Enrollment states relied heavily on data to inform and monitor policy changes. To ensure that simplifications were sound, they used strong analysis and back-end auditing to ensure that the proposed goals and outcomes of the simplification strategies were well aligned. As other states move to implement the ACA's myriad required simplifications, they can learn from these lessons when considering new pathways to further simplify and streamline their programs to maximize enrollment and promote more efficient and effective systems.

Notes

¹ Jennifer Edwards, et al., *Maximizing Enrollment for Kids: Results From a Diagnostic Assessment of Enrollment and Retention in Eight States* (Washington, DC: National Academy for State Health Policy and The Robert Wood Johnson Foundation, 2010).

² Maureen Hensley-Quinn and Andrew Snyder, *Managing Program Change: Experience From Maximizing Enrollment States in Leadership, Culture Change, Coordination* (Washington, DC: National Academy for State Health Policy and The Robert Wood Johnson Foundation, 2013).

³ United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Federal Register* 77, no. 57 (March 23, 2012).

⁴ Centers for Medicare and Medicaid Services. "Model Eligibility Application and Guidance on State Alternative Applications." Retrieved January 13, 2014. <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-04-30-2013.pdf>

⁵ United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Federal Register* 77, no. 57 (March 23, 2012).

⁶ United States Department of Health and Human Services. Centers for Medicare and Medicaid Services, State Health Official Letter: State Health Official Letter #10-003 CHIPRA #14, *Re: Express Lane Eligibility*, February 4, 2010.

⁷ Maureen Hensley-Quinn, Mary Henderson, and Kimm Mooney, *State Experiences with Express Lane Eligibility: Policy Considerations and Possibilities for the Future*, (Washington, DC: State Health Reform Assistance Network, 2012), 3.

⁸ Although Massachusetts' Section 1115 waiver was approved in December 2011, the state did not implement the new ELE policy until corresponding state plan amendments were approved for ELE processes for children under Medicaid and CHIP, later in 2012.

⁹ Express Lane Agency (ELA) is the agency that makes the original eligibility determination that is then used by Medicaid or CHIP to enroll the individual in health coverage. Examples of Express Lane Agencies include: the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families Program (TANF), the Women, Infants and Children Program (WIC) and others.

¹⁰ More information is available about the specific ELE processes that Alabama and New York used in *State Experiences with Express Lane Eligibility: Policy Considerations and Possibilities for the Future*, which can be accessed at <http://www.statenetwork.org/resource/state-experiences-with-express-lane-eligibility-policy-considerations-and-possibilities-for-the-future/>

¹¹ Mathematica Policy Research and Urban Institute, *CHIPRA Mandated Evaluation of Express Lane Eligibility: First Year Findings* (Washington, DC: Mathematica Policy Research, 2012).

¹² National Academy for State Health Policy and Urban Institute. "Maximizing Enrollment Under the ACA: Lessons from the States." CSPAN video, 1.29. December 17, 2013. <http://c-spanvideo.org/program/ActHe>

¹³ In Virginia, the early statewide implementation of procedures provides for online reporting of the newborn's birth by the hospital, leading to an expedited enrollment into Medicaid or CHIP, which is semi-automated as of January 1, 2014.

¹⁴ The Social Security Act (42 U.S.C.A. § 301 et seq.); Section 1902(e)(4)

¹⁵ Virginia, *Maximizing Enrollment Policy and System Changes Log August 2012 – October 2012* (Washington, DC: National Academy for State Health Policy, 2012).

¹⁶ State of Louisiana, *Maximizing Enrollment Transforming State Health Coverage Final Narrative Report* (Baton Rouge, LA, 2013).

¹⁷ Virginia, *Maximizing Enrollment Policy and System Changes Log May 2011 – July 2011* (Washington, DC: National Academy for State Health Policy, 2011).

¹⁸ Virginia, *Maximizing Enrollment Policy and System Changes Log July 2011 – September 2011* (Washington, DC: National Academy for State Health Policy, 2011); Virginia, *Maximizing Enrollment Policy and System Changes Log November 2011 – January 2012* (Washington, DC: National Academy for State Health Policy, 2012).

¹⁹ United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Federal Register* 77, no. 57 (March 23, 2012); 42CFR § Section 435.916

²⁰ As noted in *Managing Program Change*, states have identified different criteria for the groups eligible for participation in an administrative or continuous renewal program. "Massachusetts uses continuous renewal for approximately 400 disabled children in the state's Kaileigh Mulligan (Katie Beckett) program, and for almost 80,000 long term care members, community elders, members receiving home and community-based waiver services, Medicare Savings Program members, and persons with disabilities whose sole source of income is Social Security and who are receiving Medicare. Wisconsin piloted continuous renewal with five groups, including certain elders, persons with disabilities, and also some family planning waiver members and families with incomes less than 75% of the federal poverty level (FPL)." Maureen Hensley-Quinn and Andrew Snyder, *Managing Program Change: Experiences From Maximizing Enrollment States in Leadership, Culture Change, Coordination*, 24.

²¹ Utah, *Maximizing Enrollment Policy and System Changes Log August 2012 – October 2012* (Washington, DC: National Academy for State Health Policy, 2011); Wisconsin, *Maximizing Enrollment Policy and System Changes Log February 2011 – April 2011 & May 2011 – July 2013* (Washington, DC: National Academy for State Health Policy, 2011).

²² Maureen Hensley-Quinn and Andrew Snyder, *Managing Program Change: Experiences From Maximizing Enrollment States in Leadership, Culture Change, Coordination*, 24.

²³ State of Utah, *Maximizing Enrollment for Kids Working Smart for Utah's Kids Final Narrative Report* (Salt Lake City, UT, 2013).

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- ²⁴ Martha Heberlein, et. al., *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012 – 2013* (Washington, DC: The Henry J. Kaiser Family Foundation, 2013).
- ²⁵ United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Federal Register* 77, no. 57 (March 23, 2012), 42 CFR § 435.1200(d).
- ²⁶ University of Massachusetts Medical School, *Within Our Grasp: Achieving Full Insurance for Massachusetts Kids Maximizing Enrollment Transforming Final Narrative Report* (Boston, MA, 2013).
- ²⁷ Martha Heberlein, et. al., *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012 – 2013*.
- ²⁸ 42 CFR § 457.55(c) (grace period) and § 447.56(b) (lock-out period).
- ²⁹ 42 CFR § 457.10.
- ³⁰ Data on Beneficiaries Taking Up Option and Closure Rates, Submission from Louisiana. Edward Fowler, email to Katie Baudouin, September 4, 2013.
- ³¹ For more information on recent ACA guidance and its implications for state Medicaid and CHIP premium policies, see Tricia Brooks' blog, *New Rules Set Limits on Locking Kids Out of Coverage for Nonpayment of Premiums*. Tricia Brooks, "New Rules Set Limits on Locking Kids Out of Coverage for Nonpayment of Premiums," Georgetown University Health Policy Institute Center for Children and Families *Say Ahhh!*, July 30, 2013, <http://ccf.georgetown.edu/all/new-rules-set-limits-on-locking-kids-out-of-coverage-for-nonpayment-of-premiums/>
- ³² Maureen Hensley-Quinn, Mary Henderson, and Kimm Mooney, *State Experiences with Express Lane Eligibility: Policy Considerations and Possibilities for the Future*.
- ³³ Judy Fleisher, in discussion with Katie Baudouin and Andrew Snyder, September 9, 2013.
- ³⁴ Alice Weiss, Abigail Arons, and Julien Nagarajan, *States' Medicaid ACA Checklist for 2014*, (Washington, DC: National Academy for State Health Policy, 2013), 5.
- ³⁵ For a copy of the self-assessment toolkit, please see the enrollment section at <http://www.nashp.org>.
- ³⁶ Maureen Hensley-Quinn, phone conversation with Katie Baudouin, National Academy for State Health Policy, Washington, DC.
- ³⁷ Lynne Thomas. PowerPoint Presentation. "Maximizing Enrollment All-Grantee Web-Assisted Conference. Presented at the Maximizing Enrollment Monthly Calls, Maximizing Enrollment, Washington, DC, September 27, 2012.
- ³⁸ Lynne Thomas, in discussion with Maureen Hensley-Quinn, June 2012.
- ³⁹ Gretel Felton, Cathy Cadwell, and Vikki Brant, interview from Maximizing Enrollment Fourth Annual Grantee Meeting with Maureen Hensley-Quinn, National Academy for State Health Policy, Washington, DC, January 2013.
- ⁴⁰ Utah, *Maximizing Enrollment Policy and System Changes Log May 2011 – July 2011* (Washington, DC: National Academy for State Health Policy, 2011).